STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 02/17/2009

Director's Office

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORD HEALTH SERVICES AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Revised Report following IDR Request. Tags F281, F157, F248, F274 disputed. However no changes made to these tags. F514 changed from S/S of an E to S/S of a D. F279 and F 280 disputed. Text changes to F 279, S/S changed to an E. F280 removed. F312 disputed and removed. Text changes to F 444 and F328. An unannounced annual and complaint survey was conducted at this facility from 2/4/09 and concluded on 2/17/09. The deficiencies contained in this report are based on clinical record reviews, observations, review of the facility's policies and interviews with residents, family and facility staff. The census on the first day of the survey was 159. The sample size included 24 standard records, which included 21 active records, three closed records, and 12 supplemental residents/records for a total of 36 residents.	F 000	**Disclaimer Statement:** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of both Federal and State Laws.	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in	F 157	483.10(b)(11) NOTIFICATION OF CHANGES 1. Resident #10's family and physician were made aware of the resident's condition on 12/6/08. 2. The resident, family, or responsible party will be informed immediately, and the physician consulted should an accident resulting in injury that has the potential for requiring physician intervention; a significant change in the physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge a resident occurs.	12-6-09 4-17-09

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Fred Abatoli — Administrator — Revised 4-16-09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 157	Continued From page 1 §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of a facility incident report, it was determined that the facility failed to immediately inform the interested family members/legal representative and or physician for 2 residents (Residents #10 and #11) out of 24 sampled residents. Resident #10's family member was not immediately informed when there was an accident in the shower with an injury. The facility failed to immediately inform the family member or legal representative of Resident #11 of the significant and severe weight loss. Additionally, the facility failed to notify Resident #11's physician in a timely manner of Resident #11's severe weight loss of less than 100 lbs. Findings include: Cross refer to F323, example #3 1. Review of the facility's undated incident/accident report revealed that Resident #10 had sustained a skin tear to her right lower leg on 12/2/08 at 7:45 PM, while in the shower	F 157	483.10(b)(11) NOTIFICATION OF CHANGES (continued) 3. All nursing staff will be inserviced regarding prompt notification of resident, family or responsible party, and regarding physician consultation as indicated in #2 above no later than 4-17-09. 4. A nursing note will be completed by staff should an event as indicated in #2 above occur. These notes will be reviewed by the DON/designee daily x 90 days and reported through the QA process. If a lack of compliance is identified, we will again in-service and monitor for an additional 90 days.	4-17-09 4-17-09

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F 157	Continued From page 2 room. This incident/accident report noted that the family member was notified about the skin tear on 12/7/09, five (5) days later. The facility failed to immediately notify the interested family member about the injury. Interview with RN #2 on 2/12/09 at approximately 3 PM revealed that she had believed that the skin tear was an "old, re-opened" wound and thus she had not notified the family at the time of occurrence. 2. Cross-refer to F325, example #1 Review of Resident #11's clinical record revealed that on 4/15/08 Resident #11's weight declined to 117.1lb, a significant weight loss of 6.3 lbs (5.5%) since admission (3 weeks). There was lack of documentation that the resident's family/legal representative was notified. On 4/25/08, Resident #11's weight was down to 113.5 lbs, a severe weight loss of 9.9 lbs. or 8.4% in 1 month. There was lack of documentation to indicate that the resident's family/legal representative was notified. On 6/11/08, Resident #11's weight declined to 112.5 lbs, a severe weight loss of 10.9 lbs/8.8% in 3 months. There was no evidence that the resident's family/legal representative was informed. On 8/22/08, the Nutritional Progress Note stated that Resident #11 was being followed by Speech Therapy and the diet was downgraded to puree consistency with thick pudding liquids secondary to "Aspiration Precautions". There was no evidence that the family member/legal representative was notified of this change in the resident's condition and diet.	F 157	483.10(b)(11) NOTIFICATION OF CHANGES (continued) 1. Resident #11's physician states that she was aware of the resident's condition. The family was made aware of the resident's condition on 2-17-09. 2. The resident, family, or responsible party will be informed immediately, and the physician consulted should an accident resulting in injury that has the potential for requiring physician intervention; a significant change in the physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge a resident occurs. 3. All nursing staff will be inserviced regarding prompt notification of resident, family or responsible party, and regarding physician consultation as indicated in #2 above no later than 4-17-09.	2-17-09 4-17-09 4-17-09

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F 157	Continued From page 3 During the months of 10/08 and 11/08 there were periods of documented meal intake of less than 150% for more than 3 days. There was no evidence that the responsible party and physician were notified of Resident #11's decline in meal consumption as per facility policy. On 12/1/08, Resident #11 weighed 98.8 lbs., a 6 lbs. weight loss with no documented evidence that the resident's family/legal representative was notified. On 1/7/09 Resident #11 weighed 94 lbs. and there was no documented evidence that the physician was notified in a timely manner of this 10.8 lbs (10%) severe weight loss in 3 months since re-admission from the hospital. In an interview with the RD (Registered Dietitian) on 2/9/09, she confirmed that the physician was not notified in a timely manner. Additionally, review of Resident #11's Weights Flow sheet, Resident #11 had an insidious (gradual) weight loss from 6/11/08 through 2/4/09. There was no documentation to indicate that the resident's family/legal representative was made aware of this insidious weight loss. Resident #11 had a total weight loss of 27 lbs. since admission on 3/23/08 to 2/4/09 and there was lack of documentation that the resident's family member or legal representative was informed of this resident's severe weight loss.	F 157	483.10(b)(11) NOTIFICATION OF CHANGES (continued) 4. A nursing note will be completed by staff should an event as indicated in #2 above occur. These notes will be reviewed by the DON/designee daily x 90 days and reported through the QA process. If a lack of compliance is identified, we will again in-service and monitor for an additional 90 days.	4-17-09
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	483.15(f)(1)ACTIVITIES 1.) Resident #16 was provided with several bingo cards with raised numbers and books on tape for her enjoyment.	2-10-09

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F 248	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing program of activities designed to meet the needs of 1 (Resident #16) out of 24 sampled residents. Findings include: Resident # 16 was admitted to the facility on 12/20/06 with diagnoses that included blindness. Review of the clinical record revealed that although the resident enjoyed spending time in her room, she was not offered, nor were there any adaptations made for activities appropriate for her blindness. During an interview with the resident she stated that she would enjoy playing Bingo and listening to books on tape, but was not offered these options. During an interview with the Activities Director on 2/9/09 she stated she was unaware that Resident #16 was interested in such activities. The Activities Director then provided several Bingo cards with raised numbers and books on tape for the resident. The facility failed to provide appropriate activities for a visually impaired resident.	F 248	483.15(f)(1)ACTIVITIES(continued) 2.) An audit will be conducted to determine if any other resident has unmet activities needs. 3.) Ongoing, residents will be assessed, on admission and during the quarterly review to determine if all their activities needs are being met. If it is determined that the resident needs a special accommodation, the accommodation will be provided. 4.) The activities director will review care plans and resident interest forms to ensure that residents with special interests or accommodations have received appropriate assistance in activities. Results will be brought to the quality assurance committee meeting quarterly until substantial compliance has been met.	4-17-09 4-17-09 4-17-09
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations throughout the survey and	F 253	483.15(h)(2)HOUSEKEEPING/ MAINTENANCE 1. #1, In room B6, the vinyl reinforcement on the wall was repaired. The restroom door will be replaced. #2, In room E3, the damaged floor tiles, under the B bed have been replaced. #3, In room D14, the door jamb was repaired.	4-17-09 3-17-09 4-17-09

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F 253	Continued From page 5 staff interviews, it was determined that the facility failed to provide maintenance services necessary to maintain an orderly interior. Findings include: 1. Observations of resident room #B6 on 2/4/09 at 11:00 AM revealed that the vinyl reinforcement had separated from a wall. Additionally, the restroom door was warped. 2. Observations of resident room #E3 on 2/4/09 at 1:20 PM revealed damaged floor tiles under the B bed. The Environmental Services Director confirmed that the tiles were damaged by the motor of the electric bed. 3. Observations of resident room #D14 on 2/5/09 at 12:30 PM revealed that the restroom door was difficult to close. The Environmental Services Director confirmed that the door jamb needed to be reinforced.	F 253	483.15(h)(2)HOUSEKEEPING/ MAINTENANCE (continued) 2. An inspection of the resident rooms will be conducted by the Maintenance Director or designee, to ensure that any damage has been noted and scheduled for repair/replacement. 3. The items noted in this survey will be added to the preventative maintenance schedule. 4. The Maintenance Director will audit the compliance, with the preventative maintenance program, and report the findings to the quality assurance committee quarterly.	4-17-09 4-17-09 4-17-09
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	483.20(b)-(2)(ii), RESIDENT ASSESSMENT-WHEN REQUIRED 1. Resident #5's MDS was corrected to accurately reflect resident condition. 2. All residents have the potential to be affected by an MDS coding error. MDS's will be corrected as needed. 3. MDS assessments will be reviewed for accuracy before the final transmittal.	2-10-09 4-17-09 4-17-09

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F 274	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to complete a significant change Minimum Data Set (MDS) assessment for one (Resident #5) out of 24 sampled residents. Findings include: Resident #5 was admitted in 2005 with diagnoses including diabetes, coronary artery disease, anxiety and depression. Additional diagnoses while at the facility included dementia, dysphagia (difficulty in swallowing) and chronic kidney disease. Resident #5 had hospitalizations on 9/19/08 and 10/5/08 for congestive heart failure and returned to the facility with a feeding tube into the stomach (PEG tube) due to swallowing difficulties. Resident #5's quarterly MDS assessment, dated 08/29/08, coded locomotion on and off the unit as needing limited assistance of one person, eating was coded as supervision with set up help only and bladder continence was coded as complete bladder control. Additionally, there was no weight loss and no tube feeding noted in the 8/29/08 MDS. The 10/17/08 quarterly readmission/return MDS assessment coded locomotion on and off the unit as well as eating as total dependence with one person physical assist. Weight loss was coded as "yes" and tube feeding was checked. Additionally, the resident's bladder status declined to "frequently incontinent." The facility failed to determine within 14 days of the resident's readmission that a significant change had occurred in the resident's status and failed to complete a significant change MDS assessment.	F 274	483.20(b)-(2)(ii), RESIDENT ASSESSMENT-WHEN REQUIRED (continued) 4. The Director of Nursing/designee will review a random sample of MDS' completed that week and review them for accuracy. Any errors will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary.	4-17-09

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F 274	Continued From page 7 On 2/10/09, during an interview, the Registered Nurse Assessment Coordinator (RNAC) confirmed that the facility should have completed the MDS as a significant change MDS.	F 274	483.20(b)-(2)(ii), RESIDENT ASSESSMENT-WHEN REQUIRED (See Previous Page)	
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop a care plan for 3 (Resident's #5, #7 and #16) out of 24 sampled residents. Additionally the facility failed to ensure that the care plan was reviewed and revised for 3 (Residents #9, #11 and #18) out of 24 sampled residents. Findings include:	F 279	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS 1. Resident # 5 has a care plan in place for tube feeding and for swallowing difficulties and aspiration precautions. Resident # 7 has a care plan in place for diabetes. Resident # 16 has a care plan in place for visual impairment. The assistant care plan coordinator responsible is no longer employed with the facility. 2. The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs. 3. Information regarding resident condition is obtained on admission, at the daily staff meeting, the weekly High Risk meeting and through review of the resident record, interview, and observation. The RNAC and current assistant care plan coordinator are responsible for ensuring proper care plan documentation is reviewed at least quarterly and PRN. 4. The Director of Nursing/designee will review a random sample of resident records and care plans for accuracy. Any errors will be corrected and findings will be documented. A report of the findings will be presented at the quality assurance meetings and further actions will be planned and implemented if necessary.	#5 2-10-09 #7 2-12-09 #16 1-15-09 4-17-09 4-17-09 4-17-09

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F 279	Continued From page 8 Cross refer to F274. 1. Resident #5 returned to the facility from the hospital with a feeding tube into the stomach (PEG) due to swallowing problems. The facility failed to develop a care plan for Resident #5's tube feeding and care of the (PEG) tube as well as swallowing difficulties and aspiration precautions when the 10/22/08 Minimum Data Set (MDS) assessment was completed. On 2/10/09, an interview with the MDS coordinator confirmed the above findings. 2. Review of the clinical records revealed that the facility failed to have a care plan in place for Resident #7 who had diabetes. Finding were confirmed with the nurse manager on 2/12/09. 3. Resident #16 had diagnoses that included blindness. Review of the clinical records revealed that the facility failed to have a care plan in place for the resident's visual impairment. Findings were confirmed with the Activities Director and nurse manager on 2/9/09. Cross refer to F325, example #1 4. Review of Resident #11's clinical record revealed that this resident had a significant/severe weight loss 3 weeks after admission (3/23/08) and a continued decline through 2/4/09. Resident #11 had a total weight loss of 27 lbs. or 21% from 3/23/08 to 2/4/09. In addition, on 8/22/08 her diet was downgraded by the Speech Therapist to pureed consistency with thick pudding liquids secondary to "Aspiration Precautions".	F 279	**483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS (continued)** 1. Resident # 18 has a care plan in place for cognitive loss. Resident #11 has a care plan in place for weight loss, swallowing difficulties and aspiration precautions. Resident #9 is no longer on anti-coagulant therapy and no longer has a diagnosis of DVT. 2. A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. 3. Information regarding resident condition is obtained on admission, at the daily staff meeting, the weekly High Risk meeting and through review of the resident record, interview, and observation 4. The Director of Nursing/designee will review a random sample of resident records and care plans for accuracy. Any errors will be corrected and findings will be documented. A report of the findings will be presented at the quality assurance meetings and further actions will be planned and implemented if necessary.	#18 2-13-09 #11 2-9-09 #9 4-26-08 #9 11-14-08 4-17-09 4-17-09 4-17-09

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F 279	Continued From page 9 The facility failed to develop a care plan to reflect the severe weight loss and the Aspiration Precautions and the approaches to meet this resident's needs. 5. Resident #18 was admitted to the facility with dementia in 10/04. An annual Minimum Data Set (MDS) assessment, dated 10/9/08, had a Resident Assessment Protocol Summary (RAPS) triggered for cognitive loss and was checked to develop a care plan. There was no current care plan for cognitive loss although there had been a previous discontinued care plan reflecting, " Impaired verbal communication R/T (related to) deteriorating cognitive condition". In a 2/12/09 interview, the RNAC confirmed that the cognitive loss care plan failed to be continued even though it was checked as part of the (RAPS) on the MDS. Cross refer to F329 6. Resident #9 was re-admitted to the facility on 3/12/08 following a hospitalization where she was found to have an "acute on chronic common femoral deep vein thrombosis" (DVT-clot). Resident #9's prior medical history included a chronic subdural hematoma, hypertension, rheumatoid arthritis, stroke x 2, gastritis and upper gastrointestinal bleed. Resident #9's re-admission orders, dated 3/12/08 included administration of Lovenox and Coumadin (blood thinners, which have the potential to cause bleeding). Although the facility developed a plan of care for Resident #9, they failed to review and revised it to include the problem of the DVT and the potential	F 279	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS (continued) 1. Resident # 9 is no longer on anti-coagulant therapy ~~and no longer has a diagnosis of DVT~~. 4-24-08 2. A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. 3. Information regarding resident condition is obtained on admission, at the daily staff meeting, the weekly High Risk meeting and through review of the resident record, interview, and observation. 4. The Director of Nursing/designee will review a random sample of resident records and care plans for accuracy. Any errors will be corrected and findings will be documented. A report of the findings will be presented at the quality assurance meetings and further actions will be planned and implemented if necessary.	2-12-09 4-17-09 4-17-09 4-17-09

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10 for bleeding and required close monitoring due to anticoagulant therapy.	F 279	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS (See Previous Page)	
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews it was determined that 5 (Residents #10, #11, #13, #17, and #18) out of 24 residents in the sample failed to receive the care and services that met professional standards of clinical practice. The facility failed to follow facility policy/have a system in place to ensure that reweighs were done when residents were losing weight to verify accuracy and as indicated to initiate the appropriate interventions. Additionally, the facility failed to transcribe orders correctly for Residents #10 and #17. Findings include: According to the American Dietetic Association, "Nutritional assessment is a systematic process of obtaining, verifying & interpreting data in order to make decisions about the nature & cause of nutrition-related problems." Current standards of practice recommend weighing the resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission & at least monthly thereafter to help identify & document trends such as insidious weight loss. Weighing may also be pertinent if there is a significant change in condition, food intake has declined & persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid & electrolyte imbalance. Approaches to improving the accuracy of weights	F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS 1. Resident # 11 continues with weekly weights; her weight has fluctuated, but has not decreased significantly. She was recently hospitalized and returned on 4/13/09 with a diagnosis of possible colon cancer and failure to thrive. The responsible party requests no further gastrointestinal tests for this resident. As of 4/14/09 this resident is on Hospice. Resident #13's weight has been stable since 2/4/09 due to improved documentation. Resident #17's weight has been stable since 1/4/09 due to additional supplements. Resident #18 had been on weekly weights since 2/4/09. Her weight has fluctuated minimally since. She became a Hospice resident on 4/9/09. Resident #10 is currently on weekly weights and since 1/27/09 her weight has fluctuated with a net loss of <2%. 2. The weights of residents that have the potential to be affected will be reviewed and appropriate actions regarding their weights will be taken. The facility policy will be followed. 3. Resident's are weighed at least monthly; more frequently as determined by the Interdisciplinary Care Team. A weight change of 5 pounds	4-17-09 4-17-09

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F 281	Continued From page 11 may include reweighing the resident & recording the current weight, reviewing approaches to obtaining & verifying weight, & modifying those approaches as needed. 1. Cross-refer to F325, example #1 The facility's policy/standard of practice related to ensure accuracy of residents' monthly weight included "If a weight drops..., please reweigh and verify a loss of weight with nurse. Exception is if a resident weighs 100 lbs or less and has a 3 lb. weight loss...The weight team needs to give the weights to the ADON to update the weight committee roster. The weight team will meet weekly". The facility's Weight Flow Sheet indicated a column for the "Nurse Verifying Weight Change". Additionally, at the bottom of the the facility's Weight Flow Sheet also stated "A variance of 5 pounds, or if under 100 pounds a variance of 3 pounds, warrants re-weighing of resident." Review of Resident #11's Weight Flow Sheet revealed that this resident weighed 123.4 lbs. on admission on 3/24/08. On 4/25/08, the Resident's weight was recorded as 113.5 lbs., severe 9.9 lbs. (8.4%) weight loss in one month. This resident's Weight Flow sheet failed to indicate that a re-weigh for this 8.4% weight loss was done and verified by a nurse. In addition, according to Resident #11's Weights Flow sheet, this resident weighed 104.8 lbs. on 10/2/08. On 12/1/08, the documented weight was 98.8 lbs., a weight loss of 8 lbs. The resident's Weight Flow sheet failed to indicate that a re-weigh was done for this 8 lbs. (5.7%) weight loss in 2 month time period. On 1/7/09, the resident's weight was recorded as 94.0 lbs.,	F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS (continued) requires a re-weigh (3 pounds if a resident weighs 100 pounds or less) and notification of the Unit Manager (UM)/designee. The UM/designee will notify the Registered Dietitian (RD) of the change. The restorative aides responsible for weekly/monthly weights were inserviced 3/19/09. Remaining staff will be inserviced regarding these procedures by 4/17/09. 4. The RD will track residents that have significant weight loss and interventions previously attempted. Those residents will be discussed at the weekly High Risk meeting and be reported through the QA committee. 1. Resident # 17's orders were transcribed correctly onto the February 2009 MAR. The resident received the dose ordered and suffered no ill effect. 2. Medication orders for all residents must be written and transcribed exactly as ordered. Resident orders and MAR's will be checked to determine if other residents have been affected. 3. All Licensed staff will be inserviced by 4/17/09 regarding proper transcription of medication orders.	4-17-09 4-17-09 2-1-09 4-17-09 4-17-09

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F 281	Continued From page 12 however, the weight flow sheet failed to indicate that a re-weigh for this 10.8 lbs.(10%) weight loss in 3 months time period from 10/2/08 was verified by a nurse. Resident #11 has had documented weights under 100 lbs. since 12/1/08. Review of the RD's nutritional progress notes failed to indicate that re-weighs were done accordingly to ensure accuracy. Interview with the RD on 2/9/09 confirmed that re-weighing was not being documented according to facility policy and professional standards. 2. Resident #13 had diagnoses including cardiovascular disease, chronic obstructive pulmonary disease, diabetes and chronic renal insufficiency. The weight for Resident #13 was recorded as 167.1 lbs. on 5/16/08 and 160.2 lbs. on 6/9/08. This was a weight loss of 6.9 lbs. with no reweigh documented. 3. Resident #17 had diagnoses including stroke, congestive heart failure, diabetes and in 11/08 was diagnosed with cancer. The weight for Resident #17 was recorded as 132.8 lbs. on 7/3/08 and 126.9 lbs. on 8/25/08. This was a weight loss of 5.9 lbs. with no reweigh documented. 4. Resident #18 had diagnoses including advanced dementia, GERD (Gastroesophageal reflux disease), and anemia. The weight for Resident #18 was recorded as 110.3 lbs. on 12/7/08 and 102.8 lbs. on 1/6/09. This was a weight loss of 7.5 lbs. or 6.79% in one month. The facility failed to reweigh according to it's policy.	F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS (continued) 4. The Director of Nursing/designee will review a random sample of resident records and MAR/TAR and review them for accuracy weekly X 4, then monthly x 2. Any errors or omissions will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary. 4-17-09 1. Resident # 10's skin tear has resolved. 4-11-09 2. Treatment orders for all residents must be written and transcribed exactly as ordered. Residents orders and TAR's will checked to determine if other residents have been effected. 4-17-09 3. All Licensed staff will be inserviced by 4/17/09 regarding proper transcription of treatment orders. 4-17-09 4 The Director of Nursing/designee will review a random sample of resident records and MAR/TAR and review them for accuracy weekly X 4, then monthly x 2. Any errors or omissions will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary. 4-17-09	

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F 281	Continued From page 13 5. Resident #10 had diagnoses that included advanced dementia, hypertension and diabetes mellitus. On 6/10/08 Resident #10's weight was recorded as 122.9 and on 7/8/08 the weight was recorded as 107.4, a 15.5 lb. weight loss in one month. There was no evidence that a reweigh had been done. The clinical record revealed that from 7/16/08 through 8/10/08 Resident #10 was on weekly weights. Despite variances in weight of 5 or more lbs during this time period there was no evidence that reweighs had been done. Findings for all examples regarding the lack of reweighs were confirmed with administrative staff at the informational exit meeting on 2/17/09. Transcription Errors: 6. The facility failed to properly transcribe a physician's order onto the Medication Administration Record (MAR) in 1/09 for Resident # 17. On 1/7/09, the physician order increased the dose of the anti depressant medication. The dosage was written over in pen on the 1/09 MAR changing the dose from 30 to 60 mgs. According to the Nursing Practice Manual, the University of Connecticut Health Center, last revised on 12/07, regarding transcription of physician orders, "Medication orders are to be transcribed exactly as written in the order... If there is a change to a medication order, highlight the original order and transcribe the new medication order". During an interview on 2/12/09, the Director of Nursing confirmed that the anti-depressant medication ordered on 1/7/09 was not properly transcribed onto the 1/09 MAR. 7. Review of Resident #10's clinical record	F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS (See Previous Page)	

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F 281	Continued From page 14 revealed that she had sustained a skin tear to her right lower extremity on 12/2/08. Review of the treatment administration record from 12/2/08 through 12/7/08 indicated that the area was being cleansed with normal saline, followed with bacitracin ointment and a non-adherent dressing and gauze. Review of the physician's order sheet (POS) lacked evidence of a written order for this treatment. During an interview with RN #2 on 2/12/09, she stated that she had received a verbal order from the Nurse Practitioner but failed to transcribe it onto the POS. "Once received, verbal orders must be transcribed as a written order..." (http://www.ismp.org/Newsletters/acutecare/articles/20010124.asp?ptr=y)	F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS (See Previous Page)	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other documents as indicated, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care for 2 (Residents #9 and #12) out of 24 sampled	F 309	483.25 QUALITY OF CARE 1. Resident # 9's orders were transcribed correctly 1/1/09. The resident suffered no ill effect from the additional dose. The Physician was made aware 2/20/09. 2. Medication orders for all residents must be written and transcribed exactly as ordered. Resident orders and MAR's will be checked to determine if other residents have been affected. 3. All Licensed staff will be inserviced by 4/17/09 regarding proper transcription of medication orders.	1-1-09 2-20-09 4-17-09 4-17-09

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F 309	Continued From page 15 residents. The facility failed to follow physician's orders for the administration of Humira (antirheumatic) resulting in Resident #9 receiving one extra dose. The facility failed to ensure that Resident #12's plan of care requiring a two person assist with a stand up lift was followed. Resident #12 was transferred by one person utilizing a stand up lift which resulted in a fall with contusions of the face and head. Findings include: 1. Resident #9 had diagnoses that included rheumatoid arthritis and dementia. Resident #9 had a physician's order, dated 11/13/08 to receive, "Humira 40 mg subcutaneously every other Friday." Review of the MAR revealed that Resident #9 had received the Humira on 12/19/08. The next dose was administered on 12/27/08, eight days later and then again on 1/2/09. The facility failed to follow physician's orders for the administration of the Humira and instead gave it for 3 consecutive weeks. Findings were confirmed with the Director of Nursing on 2/9/09. 2. Resident # 12 had diagnoses that included advanced Multiple Sclerosis, dementia, ambulatory dysfunction and neurogenic bladder. According to Resident #12's annual MDS dated 4/8/08 and quarterly MDS dated 7/21/08, this resident's cognitive skills for daily decision making were "moderately impaired-decisions poor; cues/supervision required". Resident #12 was totally dependent upon staff for all activities of daily living (ADLs). Resident #12 had functional limitations in range of motion on both sides of the legs and feet and full loss of voluntary	F 309	483.25 QUALITY OF CARE (continued) 4. The Director of Nursing/designee will review a random sample of resident records and MAR/TAR and review them for accuracy weekly X 4, then monthly x 2. Any errors or omissions will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary. 1. Resident # 12 is being transferred safely according to facility policy. CNA #4 was immediately counseled on proper transfer techniques. She has since resigned (7/31/08). 2. A review of all residents who are a two person assist in transfer will be conducted to ensure that the staff is aware of which residents are two person assist.	4-17-09 4-17-09 4-17-09

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F 309	Continued From page 16 movements. Resident #12 needed physical support while standing, he was lifted mechanically for transfers (use of a mechanical device known as stand up lift) and used the wheelchair when sitting out of bed. The facility established a care plan on resident's problem for "Potential for falls R/T (related to) decreased strength and endurance dated 4/12/06. The latest quarterly reviews were dated 4/1/08 and 7/22/08. The facility's approaches to this care plan included "Provide assist of 2 for transfers", "bilateral 1/2 upper siderails as enabler" and "Stand-up lift for transfers". A nurse's note dated 5/19/08 stated, " Resident....complains of hitting his head from his fall, able to move all extremities without much difficulty---Resident was found laying on (R) side on the floor...(name of Nurse Practitioner) and ordered to send resident out to (name of hospital) for eval. (evaluation);...was pickup by ambulance at 11:10 PM." Review of the facility's investigation report, dated 5/19/08, revealed that Resident #12 was transferred to bed by a CNA, without the assistance of another CNA when using the stand-up lift as per facility protocol. During Resident #12's transfer to bed with a stand up lift, she (CNA #4) "placed resident on side of bed; after she removed the lift, he fell (slid) to the floor." In an Interview with LPN #5 on 2/17/09, she confirmed that CNA #4 transferred Resident #12 to bed alone while using a stand up lift. She did not follow the facility protocol and resident's care plan to provide assist of 2 when transferring with a stand up lift. Additionally, a Therapy Screening post fall dated 5/19/08, stated that	F 309	483.25 QUALITY OF CARE (continued) 3. All nursing staff will be inserviced by 4/17/09 regarding proper transfer techniques, the resident care profile, and care plan approaches. 4. The Unit Manager will review a random sample of resident records, care plans, and resident care profiles and will observe transfer for policy compliance. Any discrepancies will be resolved and documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary.	4-17-09 4-17-09

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F 309	Continued From page 17 Resident #12 slipped from the edge of the bed after transfer as a "result of poor bed positioning." Resident #12 returned to the facility from the hospital on 5/20/08 at 4:30 AM with a diagnosis of face and head contusion. In addition, this resident complained of generalized pain, sustained bruise on the right hand and scraped his left and right leg.	F 309	483.25 QUALITY OF CARE (See Previous Page)	
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based upon observation, record review and interview, it was determined that the facility failed to provide an environment that was free from accident hazards as was possible for 3 (Residents #10, #12 and #18) out of 24 sampled residents. The facility failed to ensure that an assistive device was properly positioned which resulted in a skin tear for Resident #10. The facility failed to properly transfer Resident #12 resulting in a injured right 5th toe. The facility failed to use an alarming seatbelt to reduce a fall risk for Resident #18 when she was seated in a geri-chair. Findings include: 1. Resident #18 had diagnoses including advanced dementia, stroke, osteoporosis and a past history of a fractured femur. An annual	F 323	483.25(h)ACCIDENTS AND SUPERVISION 1. Resident # 18's alarm battery was replaced and seat belt fastened. The resident suffered no ill effects. Alarm batteries are routinely checked weekly. 2. Those residents with battery powered alarming devices, including alarmed seat belts, have been reviewed and all alarms and seat belts are in working order and will be monitored by staff every shift. 3. A 100% review of all battery powered devices, including alarmed seat belts, will be completed. Weekly battery checks and Q shift alarm checks will be placed on the MAR. 4. The Unit Manager/designee will do random checks of alarms and seat belts for function weekly X 4, then monthly X 2 and report results through the QA committee. Further actions will be planned and implemented if the committee deems it necessary.	2-12-09 4-17-09 4-17-09 4-17-09

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F 323	Continued From page 18 Minimum Data Set (MDS) assessment, dated 10/9/08, and a quarterly MDS assessment, dated 1/5/09, both coded Resident #18 as total dependence in transfer and locomotion on and off the unit. Additionally, both MDS's noted that walking in room and corridor did not occur and the test for standing and sitting balance was unable to be attempted without physical help for resident #18. A 2/12/09 observation revealed that Resident #18 was sitting in a geri-chair with the alarming seat belt unfastened and the alarm not sounding. LPN #3 confirmed that Resident #18 was to have the alarming seatbelt fastened at all times when in the geri-chair. LPN #3 confirmed that Resident #18's seatbelt was not fastened and he fastened it. LPN #3 found the base of the alarm at the nurses' station which had no batteries in it. LPN #3 stated that he would obtain batteries for the alarm and reattach it. The facility failed to ensure that devices were functioning to reduce accident hazards for Resident #18. 2. Cross-refer to F309, example #2 Resident #12 had diagnoses that included multiple sclerosis. Resident #12 was assessed for potential for falls related to decreased strength and endurance, total care, impaired mobility and alteration in comfort related to pain. Resident #12 was totally dependent for transfers to/from bed, chair, wheelchair and standing position. Resident #12 needed a 2 person physical assist with stand up lift for transfers.	F 323	483.25(h)ACCIDENTS AND SUPERVISION (continued) 1. Resident # 12's nail has re-grown with no fungal infection. No further physician orders. CNA #3 was inserviced 3/22/09. 2. Each resident's transfer status will be reviewed for accuracy at least quarterly and PRN as part of the care plan process. Staff will be educated on the status and transfer technique. 3. All Nursing staff will be inserviced by 4/17/09 related to proper transfer techniques. 4. The Staff Developer will do random observations of transfers on each shift and report findings through the QA committee. Further actions will be planned and implemented if the committee deems it necessary.	3-17-09 3-22-09 4-17-09 4-17-09 4-17-09

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F 323	Continued From page 19 Review of Resident #12's clinical record revealed the following sequence of events: A 10/7/08 nurse's note stated, "Notified by CNA taking care of resident that resident's (r) little toe nail was bleeding. Upon entering resident's Rm (room) resident's toe was bleeding and nail very loose, almost falling off...site cleansed with nss (normal saline solution), bacitracin and CDD (clean dry dressing) applied. Resident unable to state whether he hit his little toe...". A 10/7/08 nurses's note timed 2:00 PM stated, "Spoke to resident's CNA and he states that resident probably hit his leg against the wall during transfer for his shower". The facility's incident report and investigation summary dated 2/10/09 revealed the following: Resident #12 "Bumped (r) 5th toe nail during transfer and sustained "partial debridement of 5th (r) toenail". According to CNA#3's written statement dated 2/6/09, he took Resident #12 "for shower and during transfer his right leg got in contact with the floor and his little toe started bleeding". According to LPN #4's undated written statement, "CNA called me to (number of room) to help transfer Res. (resident) from the shower chair to his w/c (wheel chair). During transfer, his (R) leg got in contact with the floor. CNA later reported that his (R) little toe was bleeding. On assessment, I noticed the little toe (nail) was loose and bleeding...". Review of the facility's incident report and investigation summary revealed that the investigation was initiated on 2/6/09 (4 months	F 323	483.25(h)ACCIDENTS AND SUPERVISION (continued) 1. Resident # 10's skin tear has resolved. 2. Each resident's transfer status will be reviewed for accuracy. Staff will be educated on the status and transfer technique. 3. All Nursing staff will be inserviced by 4-17-09 related to proper transfer techniques. 4. The Staff Developer will do random observations of positioning on each shift and report findings through the QA committee. Further actions will be planned and implemented if the committee deems it necessary.	1-11-09 4-17-09 4-17-09 4-17-09

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F 323	Continued From page 20 after the incident) and the summary of the investigation was signed by the DON on 2/10/09, a 4 month delay. On 2/10/09 at approximately 1:35 PM., in an interview with CNA#3 and LPN#4, they confirmed that they failed to use a stand up lift for transfer consistent with this resident's plan of care. Instead they supported/stabilized him physically while standing and performed a pivot turn maneuver to transfer him to his wheelchair. Resident #12's foot "got caught" on the floor during the procedure. On 2/12/09, observation of stand up lift with Resident #12 on 2/12/09 by LPN# 7 and CNA #7 revealed that this resident used a sneaker during the transfer procedure. Resident #12 was placed in a standing position with sling both under his arms. He was hunched over due to inability to stand up straight. 3. Resident #10 was admitted to the facility on 1/7/08 and had diagnoses that included advanced dementia and ambulatory/ADL (activities of daily living) dysfunction. The quarterly Minimum Data Set (MDS) assessment, dated 9/16/08 indicated this resident was totally dependent on facility staff for transfers. Review of an undated facility incident/accident report revealed that the resident had sustained an "approximate 8 cm x 6 cm" skin tear on 12/2/08 at 7:45 PM to her right lower leg while in the shower room. The incident report stated that "...4 steri strips were applied. Unable to completely cover skin tear with torn skin..." CNA #5's (certified nurse's aide) written statement, obtained by the	F 323	483.25(h)ACCIDENTS AND SUPERVISION (See Previous Page)	

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F 323	Continued From page 21 facility, was not clear as to the sequence of events leading to the skin tear. CNA #5 was not available to be interviewed. The facility's incident report investigation summary, dated 12/10/08 indicated that the "resident sustained injury while transferring from wheelchair to shower chair. Staff inserviced on proper transfer technique..." Interview with the facility staff development nurse, who conducted the inservice with CNA #5, on 2/17/09 at 11:15 AM revealed that CNA #5 failed to properly position the wheelchair leg rests while providing care. She stated that CNA #5 left the leg rests in the opened position facing forward, instead of folded back. She also stated that when the resident went to sit back in the wheelchair, she hit her lower leg on the leg rest causing the skin tear. The facility failed to ensure that assistance devices were properly positioned to prevent accident hazards.	F 323	483.25(h)ACCIDENTS AND SUPERVISION (See Previous Page)	
F 325 SS=G	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by:	F 325	483.25(i)NUTRITION 1. Resident # 11 continues with weekly weights; her weight has fluctuated, but has not decreased significantly. She was recently hospitalized and returned on 4/13/09 with possible colon cancer and failure to thrive and as of 4/14/09 is on hospice. 2. Each resident's nutritional status is monitored by the Interdisciplinary Team daily, including meal and supplement consumption. Residents weights have been reviewed to identify that appropriate interventions are in place.	17-09 4-17-09

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F 325	Continued From page 22 Based on record review, review of facility policy, observations and interviews, it was determined that the facility failed to maintain acceptable parameters of nutritional status, such as body weight and/or protein levels for four (4) residents (Residents #2, #9, #11 and #13) out of 24 sampled residents. The facility failed to monitor weight, meal and supplement consumption, failed to follow the reweigh policy, failed to revise the care plan, failed to notify the Registered Dietitian (RD) and physician (MD) of the severe weight loss sustained by Resident #11. The facility also failed to identify the insidious weight loss sustained by Resident #11. Since admission in 3/24/08 Resident #11 lost a total of 27 lbs. or 21% in 9 months which included two periods of severe weight loss occurring during her first month at the facility (8.4%) and another one two months later (8.8% in 3 months). The facility failed to administer ProSource, a protein supplement, and failed to have documented evidence of having provided a bedtime snack to Resident #9 who had a poor nutritional status. The facility failed to identify that Resident #2 had a significant weight loss of 7.5 lbs.or 5.36% in one month and failed to reweigh according to facility policy. The facility failed to accurately assess Resident #13's weight status and complete monthly weights as per policy. Findings include: Cross refer to F281 examples #1 through #5 The facility's policies entitled "Weight Team", "Weekly Weights", "Nutrition" and "Aspiration Precautions" were reviewed. 1. Cross refer to F157 example #2, F279 example #4, and F 281 example #1. Resident #11 was admitted to the facility on 3/24/08 with diagnoses that included depression,	F 325	483.25(i)NUTRITION (continued) 3. Resident's are weighed at least monthly; more frequently as determined by the Interdisciplinary Care Team. A weight change of 5 pounds requires a re-weigh (3 pounds if a resident weighs 100 pounds or less) and notification of the Unit Manager (UM)/designee. The UM/designee will notify the Registered Dietitian (RD) of the change. 4. The RD will track resident's that have significant weight loss and interventions attempted. Those residents will be discussed at the weekly High Risk meeting and be reported through the QA committee. 1. Resident # 9's order for 30 ml Pro Source T.I.D. has been transcribed correctly onto the M.A.R. is being given as ordered. 2. MAR's and TAR's will be reviewed for accuracy. Medication orders for all residents must be written and transcribed exactly as ordered. Any errors or omissions will be immediately corrected and all findings will be documented.	4-17-09 4-17-09 4-1-09 4-17-09

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F 325	Continued From page 23 GI bleed, congestive heart failure, hypertension and anemia, however, dementia was not included. According to Resident #11's admission MDS assessment dated 4/7/08, this resident ' s cognitive skills for daily decision-making were "moderately impaired-decisions poor; cues/supervision required". Resident #11 was non-ambulatory, required extensive assistance for personal hygiene and bathing, and no physical help with eating. Resident #11 had no indicators of depression, anxiety/sad mood and/or behavioral symptoms. Resident #11's admission weight was 123.4 lbs. According to Resident #11's Nutritional Assessment dated 3/26/08, her usual body weight was 124.0 and Resident #11 was on a Mechanical soft diet with NAS (no added salt). It stated that Resident #11 was offered ice cream for supplemental morning and afternoon snack, however, no documentation could be found in the resident ' s clinical record to show that she actually received and consumed the ice cream. The 4/15/08 Nutritional Progress notes stated that Resident #11's weight declined to 117.1 lb, a significant weight loss of 6.3 lbs (5.5%) in 3 weeks since admission. According to the dietary notes, this resident had a more or less 50% meal completion and was also provided an ice cream snack twice a day, although there was no documentation that she received the snack. There was also no documentation in the 4/15/08 progress note that a reweight was done, nor was this documented on the Weight Flow Sheet. This significant weight loss required a re-weight with verification by a nurse per facility policy. Ensure Plus supplement TID (three times a day) with the medication pass was added.	F 325	483.25(i)NUTRITION (continued) 3. All Licensed staff will be inserviced by 4/17/09 regarding proper transcription of medication orders. 4. The Director of Nursing/designee will review a random sample of resident records and MAR/TAR and review them for accuracy weekly X 4, then monthly x 2. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary. 1. Resident # 9's Ham and Cheese Sandwich will be noted on the MAR and staff will document percent consumed. 2. Each resident's nutritional status is monitored by the Interdisciplinary Team daily, including meal and supplement consumption. Residents weights have been reviewed to identify that appropriate interventions are in place.	4-17-09 4-17-09 3-17-09 4-17-09

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F 325	Continued From page 24 On 4/25/08 Resident #11's Weight Flow Sheet showed that her weight was down to 113.5 lbs, a severe weight loss of 9.9 lbs. or 8.4% in 1 month. There was no Nutritional Progress note to address the 1 month severe weight loss. There was no re-weight documented and verified by the nurse. There was no documented evidence that the dietitian/physician/family were notified. In addition, the facility failed to develop a care plan with interventions for this severe weight loss. On 6/11/08, Resident #11's weight declined to 112.5 lbs, a severe weight loss of 10.9 lbs or 8.8% in 3 months. There was no record of a re-weight. According to the dietary note assessment dated 6/25/08, this resident's meal completion was 50-75%. Resident #11 was also on Ensure Plus TID and ice cream snacks BID (twice a day) at that time. It stated that the resident continued to feed her self. Review of Resident #11 ' s Medication Administration Records revealed that she usually consumed all of the Ensure Plus, however there was no documentation to show that she received and consumed the ice cream from when it was ordered in 3/08 until it was discontinued in 8/08. In an interview with the facility ' s Dietary Technician (DT) she stated that she or the RD talk to nursing staff to find out if a resident is consuming an ordered snack, but the amount consumed is not documented. Hence, the facility had no system to monitor the resident ' s consumption and the effectiveness of the interventions. A significant change in status MDS assessment was done on 7/7/08. According to this	F 325	483.25(i)NUTRITION (continued) 3. The Nutrition policy has been clarified to differentiate between supplements used specifically to aid in improving overall nutritional status as opposed to foods provided to maintain or improve quality of life. Supplements used specifically to aid in improving overall nutritional status will be listed on the MAR and notation by the Licensed staff will document percent consumed. 4. The Registered Dietitian or designee will review a random sample of resident records and MAR and review them weekly X 4, then monthly x 2. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary.	4-17-09 4-17-09

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F 325	Continued From page 25 assessment, Resident #11's cognitive skills for daily decision making improved from being moderately impaired to "modified independence-some difficulty in new situations only"and she now required extensive assistance with all other activities of daily living (ADLs). Resident #11 had a weight change/loss and needed "supervision-oversight, encouragement or cueing" while eating with one person/staff assist. However, the facility still had not developed an individualized care plan for this resident to reflect the weight loss problem and to address goals and other approaches to be provided to meet her needs. On 7/28/08, Resident #11 weighed 108.8 lbs as per a dietary note dated 7/30/08. This weight was not documented on the Weight Flowsheet. The 8/22/08, Nutritional Progress Note stated that the Resident #11 was being followed by Speech Therapy and diet was downgraded to puree consistency with thick pudding liquids secondary to "Aspiration Precautions". The ice cream snack was discontinued and Ensure pudding was added. Despite this evaluation and changes of diet consistencies, the facility failed to develop a care plan and failed to address the resident's need for supervision and assistance/cueing/at all meals. Despite the aspiration precautions, review of Resident #11 ' s ADL Flowsheet dated 9/08, revealed that she ate independently for 18 of 26 days for that month. (She was hospitalized toward the end of the month.) On 9/4/08, Resident #11 weighed 104.6 lbs. A Physician's recertification assessment dated 9/5/08, indicated that the resident was still losing	F 325	483.25(i)NUTRITION (continued) 1. Resident # 9's, #2 & #13's weight is being monitored per facility policy. 2. Each resident's nutritional status is monitored by the Interdisciplinary Team daily, including meal and supplement consumption. Residents weights have been reviewed to identify that appropriate interventions are in place. 3. Resident's are weighed at least monthly; more frequently as determined by the Interdisciplinary Care Team. A weight change of 5 pounds requires a reweigh (3 pounds if a resident weighs 100 pounds or less) and notification of the UM/designee. The UM/designee will notify the RD of the change. 4. The RD will track resident's that have significant weight loss and interventions attempted. Those residents will be discussed at the weekly High Risk meeting and be reported through the QA committee.	4-17-09 4-17-09 4-17-09 4-17-09

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F 325	Continued From page 26 weight and the antidepressant Remeron 7.5 mg by mouth (po) for 7 days and then 15 mg. po every day was prescribed. In an interview with the physician on 2/11/09, she confirmed that the Remeron was prescribed both for depression and as an appetite stimulant. A dietary progress note, dated 9/25/08, stated that Resident #11 "experienced a 7.5% weight loss x 3 months and a 17.9% weight loss in 6 months"; "feed self with set-up assistance", however, in an interview with RN #1 (Unit Manager) on 2/17/09 she stated that the resident will feed herself, but does need help. The progress note also stated that "current meal completions fluctuate 25%-75%"; "resident was not taking Ensure Plus"; "will discontinue Ensure Plus and will add Magic Cup (nutritional supplement) TID with meals to aid in stability to increase po intake". Review of Resident #11 ' s MAR dated 9/08 revealed that she was consuming 100% of the Ensure Plus most of the time. When the DT was asked why she wrote that the resident was not taking the supplement when the MAR indicated that she was, she stated that she usually talks to nursing staff to find out what a resident is taking rather than relying on the MAR. When asked about the accuracy of the MAR in regards to supplements, she stated that they are working on a better system to identify how much supplement a resident is consuming. The facility failed to have a system in place to monitor the resident ' s consumption of supplements. Resident #11 was hospitalized from 9/27/08 through 10/1/08 for a hip fracture repair after a fall. On 9/22/08. prior to hospitalization, Resident #11 weighed 105.3 lbs. Re-admission weight on	F 325	483.25(i)NUTRITION (See Previous Page)	

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F 325	Continued From page 27 10/2/08 was 104.8 lbs. A physician ' s recertification/progress note dated 10/23/08, listed dementia as a diagnosis. This was the first time that this diagnosis was documented, however Resident #11 ' s quarterly MDS assessment continued to show that her cognitive skills had improved from the time she was admitted. Review of the facility ' s policy and procedure entitled, " Nutrition " revealed the following statement: " After 3 days of less than 150% total intake for the day the following will be notified by the Unit Manager and or dietitian; 1. Physician 2. Responsible Party 3. Dietary Department " Resident #11 ' s ADL sheets were reviewed for 10/08 and 11/08. From 10/15/08 through 10/18/08, she consumed less than 150% of her meals. Additionally, from 11/2/08 through 11/11/08, she also consumed less than 150% of her meals. There was no evidence that the physician or responsible party were notified that she was eating less. Review of Resident #11 ' s Weight Flow Sheet revealed that she experienced a 6 pound weight loss from 11/3/08 to 12/1/08 which represented a severe weight loss of 5.7%. However, there were no nutritional progress notes since 10/2/08 until 12/1/08 that made note of the resident ' s decrease in meal consumption and the care plan failed to be updated to reflect this change. During an interview with the RD on 2/11/09 she was asked when the care plans were revised to include new interventions after a change in nutritional status. She stated that this was done after care plan meetings. Resident #11 ' s next care plan meeting after this change was	F 325	483.25(i)NUTRITION (See Previous Page)	

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F 325	Continued From page 28 not until 1/15/09. Review of her care plan lacked any individualized interventions that specifically addressed the resident ' s weight loss and decreased appetite. In addition, when Resident #11 ' s weight dropped from 104.8 on 11/3/08 to 98.8 on 12/1/08, no reweight was done for this variance of 6 lbs weight loss under 100 lbs as per facility's instruction on the Weight Flow Sheet. The 12/17/08 dietary note identified that Resident #11's current meal completion fluctuated 25-100% with mostly 50-75%. Supercereal was added to breakfast meals. Review of the 11/08 and 12/08 MAR ' s (Medication Administration Record) regarding Magic Cup supplemental consumption with meals failed to show the percentage of the Magic Cup consumption. During an interview with the RD she stated that since the Magic Cup comes with meals, the amount consumed is just included in the total for the whole meal. A Nutritional Assessment completed by the RD on 1/02/09 stated, "nursing report that resident feeds self, however, if she is fed, she'll take more in. RD recommended to make resident a feeder and encourage po intake". There was no care plan to address this intervention. Resident #11 was observed on 2/5/09 at approximately 8:30 AM eating breakfast alone in her room contrary to the recommendation by the RD to make resident a feeder. The bed was positioned with the left side to the wall and her back to the doorway and she could not readily be observed from the hallway/door while eating in the room. Resident #11 took only a couple of spoons of the pureed food. Resident was more	F 325	483.25(i)NUTRITION (See Previous Page)	

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F 325	Continued From page 29 engrossed in watching TV rather than eating. The meal tray was incorrectly served to the resident with unthickened coffee. RN #1 came in the room at approximately 8:40 AM, and was shown the unthickened coffee. RN #1 confirmed the unthickened coffee and remained in Resident #11's room to assist and feed her. Additionally, on 2/5/09, and prior to the time above, it was observed that CNA #1 went in this resident's room twice for a few seconds but did not stay. In an interview with CNA #1 on 2/5/09 at 2:00 PM, she stated that this resident fed herself, saw her eating and she did not stay. CNA #1 also stated that she did not know that Resident #11 was on Aspiration Precautions. On 1/7/09 Resident #11 weighed 94.0 lbs. Again no reweight was done for this variance of 4.3 lbs weight loss, under 100 lbs. There was no dietary progress note to address this weight loss and no documented evidence to support that the physician was notified of this 10.8 lbs (10%) weight loss for 3 months since re-admission from the hospital. In an interview with the RD on 2/9/09, she confirmed that the physician had not been notified in a timely manner. In an interview with the resident's attending physician on 2/11/09 at approximately 1:55 PM, she stated that the resident should have been reweighed for the 94 lbs. weight for accuracy. She also stated that there was no clinical condition as to why she was losing weight. This was dementia related and she needed to be encouraged. In summary, review of Resident #11's clinical record showed an insidious (gradual) weight loss	F 325	483.25(i)NUTRITION (See Previous Page)	

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F 325	Continued From page 30 from 6/11/08 through 2/4/09. Dietary progress notes from 5/08 through 12/08 incorrectly documented that the weights were stable during this assessment period and failed to identify this insidious weight loss. Resident #11 had a total weight loss of 27 lbs. or 21% since admission. She experienced a severe weight loss of 8.4% the first month in the facility, 8.8% after 3 months and 17.9% 6 months after her admission. The facility failed to have a system in place that included the analysis of recorded meals and all supplements consumed. 2a. Resident #9 was re-admitted post hospitalization on 11/13/08 with diagnoses that included fever and urosepsis (bloodstream infection from a urinary tract infection). Review of the hospitals' "chemistry profile," dated 11/7/08 revealed Resident #9's results as follows: Total Protein=4.5 (reference: 6.1-8.3 G/DL); Albumin=2.2 (reference: 3.8-5.1G/DL); and Prealbumin=15 (reference: 17-42 mg/DL). These three blood tests indicated that Resident #9's nutritional status was poor. On 11/14/08, a physician's order was written for the resident to receive, "30 ml (milliliter) ProSource TID (three times daily) @ med pass." The facility failed to transcribe the order onto the medication administration record (MAR). A 24 hour chart check, dated 11/15/08 was signed off as having been completed by the 11 PM -7 AM shift. The 24 hour chart check indicated that all physician's orders written in the preceding 24 hours had been reviewed. Despite this review, the facility failed to identify that the order had not been transcribed onto the MAR. Review of MARs from 11/14/08 through 2/9/09 lacked evidence that the ProSource had been	F 325	483.25(i)NUTRITION (See Previous Page)	

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F 325	Continued From page 31 administered as ordered. The facility failed to administer ProSource for approximately three months or a total of 260 doses. Review of the clinical record indicated that no further laboratory tests for total protein, albumin and prealbumin had been ordered. During an interview with the Registered Dietitian (RD) on 2/9/09 at 12:15 PM, she confirmed that when ProSource is ordered it should be documented on the MAR. On 2/12/09 at 10 AM, the RD confirmed the findings and stated, "I assumed the orders were implemented." 2b. Review of Resident #9's nutrition note, dated 12/6/08 indicated that a ham and cheese sandwich would be ordered for a bedtime snack to increase the resident's oral intake. Although a dietary communication slip was submitted, the facility failed to transcribe an order onto the physician's order sheet. Review of the dietary nourishment list included the sandwich at bedtime for Resident #9, however review of medication administration records from 12/7/08 through 2/9/09 lacked documented evidence that the snack had been provided and consumed. During an interview with the Registered Dietitian on 2/9/09 at 12:15 PM when asked how she verifies that the snack is given and consumed, she stated that she would ask the Certified Nurse's Aides (CNA). When asked if she spoke with the evening shift CNAs, she stated no, she would ask the day shift CNAs. When questioned how the day CNAs would know this, she stated they would tell each other in report. 2c. Resident #9 had diagnoses that included dementia, stroke x 2 and depression. The	F 325	483.25(i)NUTRITION (See Previous Page)	

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F 325	Continued From page 32 residents' 4/28/08 weight was recorded as 111.6 and 106.2 on 5/28/08. This was a 5.4 lb weight loss in one month. There was no evidence of a reweigh. On 1/27/09 Resident #9's weight was recorded as 112.3. A weekly weight on 2/2/09 was recorded as 124.2 with a notation, "new chair need reweigh." The facility did not reweigh the resident until 2/10/09, eight days later. During an interview with the Registered Dietitian on 2/9/09, she stated that reweighs should be completed within 24 to 48 hours of the initial weight. 3. Resident #2 had diagnoses that included dysphagia, stroke and dementia. The residents' 9/08 monthly weight was recorded as 139.7 lbs. and the 10/08 monthly weight was 132.2 lbs. This was a 7.5 lb. or 5.36 % weight loss in one month. The facility failed to identify this significant weight loss and reweigh according to it's policy. 4a. Review of Resident #13's Nutritional Progress note, dated 10/28/08, inaccurately documented weights for 4/08 and 7/08 which were actually 2007 weights. This led to additional inaccurate documentation, "20% weight (loss) in 3 months and 24.3% weight (loss) in six month (sic) are significant changes". 4b. Additionally, there was no monthly weight recorded for Resident #13 during 8/08. The facility failed to accurately document Resident #13's weight status in the 10/28/08 quarterly Nutritional Progress note and failed to document a monthly weight in 8/08. In an interview on 2/10/09, the Registered Dietician (RD) confirmed the errors noted above and the lack of a monthly weight for 8/08.	F 325	483.25(i)NUTRITION (See Previous Page)	
F 328	483.25(k) SPECIAL NEEDS	F 328	483.25(k)SPECIAL NEEDS (See Following Page)	

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F 328 SS=E	Continued From page 33 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure that 5 (Residents #7, #14, #16, #20 and #21) out of 24 sampled residents received proper foot care. Additionally, based on observation and staff interview, it was determined that the facility failed to ensure that respiratory equipment (concentrators) was maintained in a clean manner for 6 (Residents #1, #6, and SS#33 through SS#36). Findings include: 1. Resident #21 was admitted to the facility on 2/2/05 and had diagnoses that included gout, peripheral vascular disease and diabetes mellitus. The care plan, dated 7/18/08 and entitled, "Potential for uncontrolled blood sugars related to diabetes mellitus," included the approaches, "...close attention to feet...Podiatry consults as needed..." The 2/09 monthly physician's order sheet stated, "Podiatry management as needed." Resident #21's clinical record revealed a signed consent, dated 6/24/08 for the authorization of	F 328	483.25(k)SPECIAL NEEDS 1. Resident #21's nails were trimmed on 3/23/09 by the Podiatrist. Resident #7's nails were trimmed on 2/12/09 by the Podiatrist. Resident #16's nails were trimmed by the Wound Care Nurse on 3/17/09. Resident #20's nails were trimmed on 3/5/09 by the Podiatrist. Resident #14's nails were trimmed on 2/12/09 by the Podiatrist. Resident #14 continues with Lac-Hydrin to her feet to moisturize her skin. 2. The Wound Care Nurse completed a 100% audit of residents podiatry needs. Podiatry care rendered as necessary. 3. Residents will be assessed to determine the type of foot care required to meet their individual needs. Routine foot care is provided by the Nursing Department unless medically contra-indicated as determined by the Physician and/or the Podiatrist. The weekly skin check sheets have been revised to include assessment of toenails. The Wound Care Nurse will communicate with and inform the Podiatrist of any related resident needs.	#21 3-23-09 #7 2-12-09 #16 3-17-09 #20 3-5-09 #14 2-12-09 4-17-09 4-17-09 4-17-09

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F 328	Continued From page 34 podiatry services with a new podiatry provider. This document stated that routine foot care services (i.e. trimming of toenails) is done "approximately every three months, and is an important part of patient care to prevent infection and amputation." Record review revealed that the last podiatry consult for Resident #21 had been on 8/2/07. Observation of Resident #21's feet on 2/12/09 at 8:00 AM revealed thick, elongated toenails in need of trimming. During an interview with the facility's wound care nurse on 2/12/09 at 11:00 AM, she confirmed that there was no evidence that Resident #21 had received any podiatry services since 8/2/07. 2. Resident #7 was admitted to the facility on 10/6/07 with diagnoses that included diabetes and aphasia (inability to express oneself verbally). Review of the clinical record revealed a signed consent for podiatry services dated 10/6/07 but no documented visits from a podiatrist from 10/6/07 to current. During an interview with the Wound/Treatment nurse on 2/9/09, she stated that she was unsure who had been trimming Resident #7's nails or monitoring his feet. A new consent was obtained on 2/10/09 and Resident #7 was seen by a podiatrist on 2/12/09. 3. Resident #16 was admitted to the facility on 12/20/06 with diagnoses that included diabetes and blindness. Review of the clinical record revealed a signed consent for podiatry services dated 12/21/06, with the last podiatry visit dated 5/17/07. During an interview with the Wound/Treatment	F 328	483.25(k)SPECIAL NEEDS (continued) 4. The Wound Care Nurse/designee will track foot care via Skin Sheets and communication with the Podiatrist. Omissions will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary. 1. Residents #1, #6, #33, #34, #35, #36 have had Oxygen concentrator filters cleaned or replaced. 2. The Maintenance department has completed a 100% audit of O2 concentrators. Filters cleaned as necessary. 3. The Maintenance Department will ensure that Oxygen concentrator filters are cleaned or replaced as part of the Preventive Maintenance program every two weeks.	4-17-09 3-17-09 3-17-09 4-17-09

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F 328	Continued From page 35 nurse on 2/10/09 she stated that Resident #16's grandson trimmed the resident's nails. The facility failed to ensure that trimming of the resident's toe nails were managed by a podiatrist to avoid foot problems for this diabetic resident. On 2/16/09 the Wound nurse stated that she was unable to contact Resident #16's family for a new consent and that she would be monitoring the resident's feet until a consent was obtained. 4. Review of Resident #20's clinical record revealed a signed consent for podiatry services dated 2/3/05, with the last podiatry visit dated 7/19/07. There were no documented podiatry visits since 7/19/09 to current. These findings were discussed with the Wound/Treatment nurse on 2/10/09 and a new signed consent was obtained on 2/10/09, with a podiatry visit scheduled later in 2/09. 5. Resident #14 was diagnosed with Down's Syndrome and dementia and was totally dependent for grooming, personal hygiene and bathing. Record review revealed a Podiatry consent form, dated 1/26/06. On 2/10/09, an interview with the Treatment/Wound nurse revealed that the consent was not current due to change of Podiatrists. A Podiatry note, dated 11/12/07, stated, "nails are long and becoming painful... nails were debrided and this provided immediate relief." There was no evidence of any Podiatry services since 11/12/07. A physician's order, dated 5/13/08 stated, "Podiatry consult - mycotic (fungal infection) nails". On 2/10/09, an interview with LPN #6	F 328	483.25(k)SPECIAL NEEDS (continued) 4. The MaintenanceDirector/designee will track filter cleaning/ replacement. Omissions will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary.	4-17-09

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F 328	Continued From page 36 confirmed the lack of the Podiatry consult. LPN #6 stated that without a current consent, the Podiatry consult for Resident #14, "was probably not done". The facility failed to ensure that Resident #14 had an updated Podiatry consent to provide services to Resident #14 in a timely manner. In an interview on 2/11/09, the Treatment/Wound nurse stated that a verbal consent via telephone from Resident #14's family was obtained and that the Podiatrist would see her on 2/12/09. Additionally, the facility failed to provide personal hygiene and grooming to Resident #14. A 1/12/09 Nurses' note documented, "staff noted 2nd L (left) toenail on the sheets". On 2/9/09, an observation of Resident #14's toenails was made with LPN #1. Toenails were thick and the left 4th toenail was long and curved downward. There was no open area on the left 2nd toe where the toenail had come off. The skin on all of Resident #14's toes was dry, flaky and crusty in appearance. LPN #1 confirmed the condition of Resident #14's feet and stated that she would apply some lotion to them. On 2/9/09, in an interview, LPN #2 stated that the Certified Nurse Aides (CNAs) file/cut Resident #14's fingernails and that nurses can cut her toenails. However, she advised checking with the Treatment/Wound nurse. On 2/10/09, an observation of Resident #14's toenails was made with the Treatment/Wound nurse. The Treatment/Wound nurse confirmed	F 328	483.25(k)SPECIAL NEEDS (See Previous Page)	

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F 328	Continued From page 37 this surveyors finding from 2/9/09. Additionally, the skin between the 4th and 5th right toes was white and macerated. The Treatment/Wound nurse stated that the nurses would not be able to cut the resident's toenails since they do not have the appropriate tools to cut such thick nails and would address foot concerns with the resident's physician. The facility failed to provide personal hygiene related to foot care for Resident #14. On 2/10/09, an interview with the LPN #6 confirmed that toenail and foot care needs for Resident #14 were not being provided. 6. During a tour of the facility on 2/4/09, the concentrator filters of Residents #1, #6, #33, #34, #35, and #36 had a thick layer of dust. An interview with the unit manager revealed that the maintenance department was responsible for replacing the filters.	F 328	483.25(k)SPECIAL NEEDS (See Previous Page)	
F 329 SS=G	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	483.25(l) UNNECESSARY DRUGS 1. Resident #9's has not received anticoagulant therapy since April 2008. 2. In April 2008, residents receiving anti-coagulant therapy were identified, as such, by a fluorescent colored page in the front of their medical record to alert the staff.	4-17-09 4-17-09

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F 329	Continued From page 38 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of hospital records and interviews, it was determined that the facility failed to ensure that one (Resident #9) of 24 sampled residents' drug regimen was free from unnecessary drugs. The facility administered 2 doses of Lovenox (an anticoagulant) after being discontinued by the physician and failed to adequately monitor Resident #9's PT/INR (Prothrombin Time/International Normalization Ratio-measure blood coagulation) in order to minimize adverse consequences. Resident #9 had been newly started on Coumadin (anticoagulant) therapy, had diagnoses which placed her at high risk for bleeding and was receiving concomitant medications known to increase Coumadin's effect. Despite the onset of bruising on 4/16/08, the facility failed to identify the adverse consequence of Coumadin toxicity and continued to administer Coumadin for two additional days. A PT/INR was not drawn until 4/18/08, 28 days after the last dose of Coumadin was administered, when additional bruising occurred. Findings include: Cross refer to F279, example #6 "Standards for Warfarin (Coumadin) Monitoring: A test called International Normalization Ratio (INR) is the lab test that is routinely performed to	F 329	483.25(l) UNNECESSARY DRUGS (continued) 3. The facility policy has been amended on 2/20/09 to state that any resident receiving Coumadin therapy will have a PT/INR drawn weekly and the result called to the physician, unless otherwise ordered by the Physician. This policy was provided to the survey team upon request. 4. The Director of Nursing/designee will continue to monitor PT/INR orders and results. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary.	2-20-09 4-17-09

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F 329	Continued From page 39 monitor warfarin levels. For most individuals a stable, safe INR level will be between 2 and 3.5...When a warfarin regimen is started, a baseline INR is typically obtained...After the initial INR, follow-up INRs may be done every three to five days. INRs are then continued every three to five days until two consecutive stable therapeutic INR readings are established. After the two consecutive INR readings are obtained that are between 2 and 3.5, guidelines support INRs to be drawn weekly for four weeks. When a resident is stable after the weekly INRs, then an INR will be performed every four weeks as long as warfarin is being used. NOTE: The above standards are clinically supported and published by the American College of Chest Physicians..." (http://dhs.wisconsin.gov/rl_DSL/Publications/08-002.htm) The Coumadin manufacturer package insert states, "...can cause major or fatal bleeding. Bleeding is more likely to occur during the starting period...Risk factors for bleeding include...history of gastrointestinal bleeding...cerebrovascular disease...concomitant drugs...Regular monitoring of INR should be performed on all treated patients. Those at high risk of bleeding may benefit from more frequent INR monitoring...report immediately to physician's signs and symptoms of bleeding (i.e. bruising)...The following factors, alone or in combination, may be responsible for INCREASED PT/INR response: collagen vascular disease (i.e. rheumatoid arthritis)...Specific drugs reported: allopurinol, metronidazole (Flagyl), Prednisone, lansoprazole (Prevacid)...cranberry products are associated most often with an INCREASE in the effects..."	F 329	483.25(l) UNNECESSARY DRUGS (See Previous Page)	

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F 329	Continued From page 40 Resident #9 was re-admitted to the facility on 3/12/08 following a hospitalization where she was found to have an "acute on chronic common femoral deep vein thrombosis" (DVT-clot). Resident #9's prior medical history included a chronic subdural hematoma (an 'old' collection of blood and blood breakdown products between the surface of the brain and it's outermost covering, the dura), hypertension, rheumatoid arthritis, stroke x 2, gastritis and upper gastrointestinal bleed. A significant change Minimum Data Set (MDS) assessment, dated 2/8/08 indicated the resident's cognitive skills for daily decision making were independent-decisions consistent/reasonable and that she had no short or long term memory problems. Physician's re-admission orders, dated 3/12/08 included, "Lovenox (anticoagulant) 1 mg/kg 60 mg subcutaneously BID (twice daily) D/C (discontinue) when INR greater than or equal to 1.8; Coumadin (anticoagulant) 5 mg by mouth qHS (every bedtime)" and "PT/INR next lab." Resident #9's re-admission orders also included the following medications: Allopurinol 100 mg daily, Flagyl 500 mg three times a day for 10 days (completed on 3/21/08), Prednisone 5 mg daily, Prevacid 30 mg daily, and Cranberry capsules 475 mg twice daily. Although the facility developed a plan of care for Resident #9, they failed to review and revise it to include the problem of the DVT and the potential for bleeding and close monitoring required for anyone on anticoagulant therapy. The clinical record revealed that a PT/INR was drawn on 3/14/08. The reported values were PT 36.1 (limits: 11.1-13.7) and INR 7.16. A	F 329	483.25(l) UNNECESSARY DRUGS (See Previous Page)	

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F 329	Continued From page 41 physician's order was obtained to "Hold Coumadin, Vitamin K (counteracts the anticoagulant effects of Coumadin) 5 mg x 1 (today) by mouth and Repeat INR 3/15/08." Given the INR results obtained on 3/14/08, the facility had orders to discontinue the Lovenox. Despite this order, the medication administration record (MAR) revealed that the facility continued to administer the Lovenox for 2 more doses (3/14/08 at 9 PM and 3/15/08 at 9 AM). The 3/15/08 PT/INR indicated the values PT 30.9 and INR 5.38. Physician's orders, dated 3/15/08 stated, "hold Coumadin today 3/15/08 and tomorrow 3/16/08, repeat PT/INR on Monday 3/17/08." The MAR revealed that the Coumadin was held per physician's orders. The PT/INR drawn on 3/17/08 revealed values PT 18.4 and INR 2.06. Physician's orders, dated 3/17/08 stated, "New order-Coumadin 4 mg PO (by mouth) qHS, Repeat PT/INR 3/21/08." The 3/21/08 PT/INR values were PT 19.4 and INR 2.28. The 3/21/08 laboratory report was initialed by the physician on 3/24/08, indicating it was reviewed, however there were no orders written for the next PT/INR. Resident #9 continued to receive Coumadin 4 mg daily. The clinical record indicated that Resident #9 was seen by the physician on 3/26/08 and by the Nurse Practitioner (NP) on 4/8/08 for recertification visits. Neither note mentioned that the resident was on Coumadin and/or the frequency of the PT/INRs. A nurse's note, dated 4/16/08 and timed 4:30 PM stated, "Resident c (with) bruise/hematoma	F 329	483.25(l) UNNECESSARY DRUGS (See Previous Page)	

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F 329	Continued From page 42 (collection of clotted or partially clotted blood within an organ or soft tissue space caused by a break in the wall of a blood vessel) noted to (right) upper chest (complained) tender to touch Dr. (name) in house (new order) X Ray R anterior chest wall..." The physician's note, dated 4/16/08 stated, "(patient) c bruise & lump R ant chest wall. Pt denies any trauma...palpable, mobile & tender lump R ant CW (chest wall) c overlying bruise...likely some trauma as pt has bruise. ?hematoma vs. soft tissue swelling (check) x ray." There was no evidence that the facility considered that the bruising was a result of Coumadin toxicity at this time. Despite the residents' denial of any trauma, the facility failed to obtain a PT/INR and continued to administer Coumadin 4 mg on 4/16/08 and 4/17/08. The X ray report, dated 4/16/08 revealed no abnormal findings. A nurse's note, dated 4/18/08 and timed 11:15 AM stated, "...summoned to room...Bruise on right chest wall very hard & painful to touch. Bruise covers large portion of upper breast area and spreads toward sternal area. New bruises noted on left flank, right hip, and left shin. Bruise on left flank covers a large surface area extending to rib cage & upper hip area. The bruises on her R hip & left shin are the size of a half dollar piece...no (sign/symptoms) trauma visualized. Resident is unaware of any trauma. Meds reviewed. She is on Coumadin...last INR drawn 3/21/08...notified NP...also has (history of) GI bleed...orders received for stat (immediately) complete blood count with differential, liver function tests, & PT/INR." A second nurse's note, dated 4/18/08 and timed 1:30 PM stated that the resident had an elevated temperature, a pulse	F 329	483.25(l) UNNECESSARY DRUGS (See Previous Page)	

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F 329	Continued From page 43 oximetry reading of 77% (normal above 92%) and that she was sent out to the emergency room via 911 and was subsequently admitted to the hospital. The PT/INR drawn in the facility indicated results as PT 58.0 and INR 17.23. The hospital history & physical, dictated on 4/18/08 stated, "...noted to be hypotensive with systolic pressure initially at 50 (normal above 90)...number of bruises across her right anterior chest as well as her left flank area causing pain...noted to have a hemoglobin of 7 (reference: 11.7-15.7 GM/DL) as well as an INR at 13.4 (the laboratory report states, "Critical Alert-the PT is greater than 99.9 seconds making the INR greater than 13.4)...Head CT shows an acute on chronic subdural hematoma...abdominal CT scan has a left lower flank hematoma. Impression: Anemia and severe coagulapathy (condition of the blood clotting system in which bleeding is prolonged and excessive)...secondary to Coumadin...heme-positive (containing blood) stools..suspect that this is the reason for her blood loss...can not be placed on anticoagulants...may need to consider an IVC filter (device implanted into the inferior vena cava to prevent pulmonary emboli)..." Further review of the hospital record revealed Resident #9 required transfusion with 4 units of packed red blood cells to correct the anemia and 3 mg of Vitamin K, plus 4 units of fresh frozen plasma to correct the coagulapathy. Additionally, hospital records noted placement of an IVC filter on 4/21/08, since anticoagulation was no longer an option. Resident #9 was hospitalized until 4/25/08, at which time she returned to the facility. In an interview with the Director of Nursing (DON)	F 329	483.25(l) UNNECESSARY DRUGS (See Previous Page)	

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F 329	Continued From page 44 on 2/9/09 at 12:00 PM, he confirmed that no monitoring of the PT/INR was done from 3/22/08 through 4/17/08. Additionally, he confirmed that when the initial bruising occurred on 4/16/08 no one thought of Coumadin effects until 2 days later when the bruising increased. The DON stated that after the occurrence, the physician re-evaluated all the resident's in the facility who were on Coumadin and "a system" was developed to prevent this type of re-occurrence. Despite a request for a copy of the facility's new policy/protocol, none was received by the survey team. During an interview with Resident #9's physician on 2/11/09, she confirmed that no physician's orders had been written for PT/INRs after 3/21/08 and that the Nurse Practitioner "did not realize no further INR was ordered...I know, I take responsibility."	F 329	483.25(l) UNNECESSARY DRUGS (See Previous Page) 483.25(m)(2) MEDICATION ERRORS 1. Resident # 9's orders were corrected on 1/1/09. The resident suffered no ill effect. 2. Medication orders for all residents must be written and transcribed exactly as ordered. Resident orders and MAR's will be checked to determine if other residents have been affected. 3. All Licensed staff will be inserviced by 4-17-09 regarding proper transcription of medication orders. 4. The Director of Nursing/designee will review a random sample of resident records and MAR/TAR and review them for accuracy weekly X 4, then monthly x 2. Any errors or omissions will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary.	1-1-09 4-17-09 4-17-09 4-17-09
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, it was determined that the facility failed to ensure that one (Residents #9) out of 24 sampled residents were free of significant medication errors. Findings include: Resident #9 had a physician's order, dated 11/13/08 to receive, "Risperdal (antipsychotic agent) 0.25 mg 1 tablet by mouth twice a day every morning and every evening." Review of the 12/08 medication administration record revealed	F 333		

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F 333	Continued From page 45 that the facility failed to administer the evening dose of Risperdal for the entire month, a total of 31 doses. Findings were confirmed with the Director of Nursing on 2/9/09 at 3:30 PM.	F 333	483.25(m)(2) MEDICATION ERRORS (See Previous Page)	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that – (i) Before offering the pneumococcal	F 334	483.25(n)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION 1. Resident's # 3, #21 & #2 has received the Pneumococcal vaccine. 2. A 100% audit of Pneumococcal Vaccine administration has been completed. 3. Residents or their legal representative will receive a consent that indicates acceptance or refusal of the Pneumococcal vaccine including information regarding benefits and side effects of the immunization. The signed consent will be placed on the resident's medical record. The RNAC/designee will track the consents and will notify the resident or legal representative and the physician of any boosters required.	2-4-09 2-4-09 4-17-09

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F 334	Continued From page 46 immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on review of the clinical records and interview, it was determined that the facility failed to follow facility policy and failed to ensure that before offering the pneumococcal immunization,	F 334	483.25(n)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION (continued) 4. The RNAC/designee will review resident records to ensure compliance. Any errors or omissions will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary. 1. Residents # 25, #26, #27, #28, #29, #30, #31, #32, #33 have received the Pneumococcal vaccine. 2. A 100% audit of Pneumococcal Vaccine administration has been completed. 3. Residents or their legal representative will receive a consent that indicates acceptance or refusal of the Pneumococcal vaccine including information regarding benefits and side effects of the immunization. The signed consent will be placed on the resident's medical record. The RNAC/designee will track the consents and will notify the resident or legal representative and the physician of any boosters required.	4-17-09 2-4-09 2-4-09 4-3-09

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F 334	Continued From page 47 two (2) sampled resident's (Resident #3 and #21) or the legal representative received education regarding the benefits and potential side effects of the immunization. In addition, the facility failed to ensure that a re-vaccination (booster)pneumococcal vaccination was given to 66 year-old Resident #3 and to 70 year old Resident # 21, after 5 years following their first pneumococcal immunization below 65 years of age. Additionally, 8 sub-sampled "immunocompetent" and "immunocompromised" residents did not receive the Pneumovax re-vaccination (booster) until 2/4/09 (6 or more years). Findings include: The facility's policy entitled "Policy for Pneumococcal Vaccination for Residents" stated, "...If an immunocompetent resident was 65 years of age or less at the time of initial vaccination, and more than 5 years have elapsed since initial vaccination, one booster dose of vaccine will be offered. In an immunocompromised resident, the vaccination should be repeated once if 5 years have elapsed since initial vaccination, regardless of age at the time of initial vaccination. Resident SS#25's pneumovax vaccine was last administered on 7/96 at age 36 - Booster was administered on 2/4/09, 13 years later. Resident SS#26's pneumovax vaccine was last administered on 2/03 at age 55 - Booster was administered on 2/4/09, 6 years later. Resident SS#27's pneumovax vaccine was last administered on 1/03 at age 60 - Booster was administered on 2/4/09, 6 years later. Resident SS#28's pneumovax vaccine was last	F 334	483.25(n)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION (continued) 4. The RNAC/designee will review resident records to ensure compliance. Any errors or omissions will be immediately corrected and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary.	4-3-09

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F 334	Continued From page 48 administered on 7/03 at age 61 - Booster was administered on 2/4/09, 6 years later. Resident SS#29's pneumovax vaccine was last administered on 11/03 at age 21 -Booster was administered on 2/4/09, 6 years later. Resident SS#30's pneumovax vaccine was last administered on 04/03 at age 45 - Booster was administered on 2/4/09, 6 years later. Resident SS#31's pneumovax vaccine was last administered on 02/03 at age 40 - Booster was administered on 2/4/09, 6 years later. Resident SS#32's pneumovax vaccine was last administered on 01/03 at age 58 - Booster was administered on 2/4/09, 6 years later. This finding was discussed and confirmed by the Infection Control Nurse on 2/17/09 at approximately 2:15 PM.	F 334	483.25(n)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION (See Previous Page)	
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by:	F 441	483.65(a) INFECTION CONTROL 1. The Director of Nursing and the Infection Control Nurse have restructured the Infection Control Program to include the collection of Infection Line listings from each Unit Manger on a consistent basis. Information gathered is thoroughly investigated and analyzed to systematically help prevent or control the spread of infection.	4-17-09

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F 441	Continued From page 49 Based on record review and interview with the infection control nurse, it was determined that the facility failed to maintain an infection control program designed to prevent the development and transmission of disease and infection for more than a four month period. Findings include: In an interview with the current RN Infection Control Nurse (ICN) on 2/17/09 at approximately 9:25 AM, it was revealed that she was hired on 10/13/08 as Staff Development Nurse/Infection Control Nurse. Prior to her arrival, the previous ADON was the Infection Control Nurse until April, 2008. The previous RN Staff Development nurse who also worked with the ADON on the Infection Control Program left 7/31/08. The ICN stated that the Monthly Infection Control reports for the months of January, February and March of 2008 and through to July, 2008 were missing. It took 8 days for the Infection Control Nurse to put together the monthly Infection Control Log for the time period of 8/08 through 1/09. Review of these Monthly Infection Control Logs revealed that the facility monitored the occurrence of the infection (for example, UTI which was most prevalent), however it failed to identify the type of organisms infecting the residents and failed to trend the organisms to determine if there was a pattern of infection that the facility needed to address and corrective actions that needed to be taken. Review of the these Monthly Infection Control Log also revealed that the infections were at times either not included on the line listing. Other infections listed were pneumonia, upper respiratory infection, cellulitis, scabies, D- diff and MRSA. Additionally, the facility failed to provide an	F 441	483.65(a)INFECTION CONTROL (continued) 2. A new program to consolidate and review infection control has been established. After reviewing collected data, the facility learned that no residents had been affected. 3. Residents are assessed and monitored each shift by the Nursing Department. Signs or symptoms of infection are reported as needed to the Physician and supervisor and the findings are documented. New Infection Control line listings have been created that includes type of organism and location of resident affected to ascertain if patterns exist. The Infection Control Nurse in consultation with the Interdisciplinary Care Team will more formally document the investigation of infections, and continue to control and prevent the spread of infection. 4. The Infection Control Nurse will track and monitor infections and all findings will be documented. A report of the documented findings will be presented at the facilities quality assurance meetings and further actions will be planned and implemented if the committee deems it necessary.	4-17-09 4-17-09 4-17-09

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F 441	Continued From page 50 established infection control program under which it investigates, analyzes any increase in the rate of infection, controls and prevents infections in the facility.	F 441	483.65(a)INFECTION CONTROL (See Previous Page)	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy it was determined that the facility failed to ensure that staff washed their hands in accordance with accepted professional practice and facility policy. The facility's policy for incontinent/perineal care states, "...9. Remove gloves and wash hands. 10. Return resident to clean, comfortable position...11. Wash hands before continuing to next task/area..." On 2/12/09 at 1:45 PM, LPN #2 was observed providing incontinence care for Resident #10, who had been incontinent of a large, soft stool. After placing a clean diaper under the resident LPN #2 removed her left glove and opened the resident's dresser drawer looking for ointment. LPN #2 re-gloved the left hand and squeezed ointment onto the left hand. The tube of ointment was touched by the soiled right gloved hand. After securing the diaper, LPN #2 proceeded to touch the bedding, bed alarm, and bed controls with her soiled gloved hands.	F 444	483.65(b)(3) PREVENTING SPREAD OF INFECTION 1. Resident # 10's perineum was re-cleansed by LPN #2 and the resident suffered no ill effect. 2. Incontinent residents that have the potential to be affected will be observed by nursing staff during their care to determine if the proper technique is being followed. 3. All Nursing staff will be inserviced by 4/17/09 related to providing appropriate personal hygiene and grooming to residents. A mannequin has been obtained to help demonstrate proper perineal care and for the Staff Developer/Infection Control Nurse to observe via return demonstration. The facility has purchased a "Glitter-Bug" light to graphically demonstrate proper handwashing technique to the staff.	2-12-09 4-17-09 4-17-09

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F 444	Continued From page 51 LPN #2 double bagged the soiled items, discarded her gloves and proceeded down the hall where she punched in the code for the door of the soiled utility room. After exiting the utility room LPN #2 used a sanitizing hand gel, returned to the resident's room to check on her. LPN #2 left the resident's room, used hand gel again, then went to the nurse's station where she used the telephone. The facility failed to ensure that cross-contamination of surfaces did not occur and that proper handwashing was completed after the removal of soiled gloves. Additionally on 2/12/09 at 1:45 PM, LPN #2 was observed providing incontinence care for Resident #10, who had been incontinent of a large, soft stool. LPN #2 properly cleansed the buttock area with disposable wipes in a front to back motion. After turning the resident onto her back, LPN #2 cleansed the groin and outer perineal areas. A clean diaper was placed under the resident, ointment was applied and as LPN #2 was pulling the diaper up to secure, she was asked to re-cleanse the labia. Upon doing so, the wipe was found to be soiled with stool. The facility failed to ensure that Resident #10 received proper perineal care. Findings were confirmed with LPN #2 and the Director of Nursing during separate interviews on 2/12/09.	F 444	483.65(b)(3) PREVENTING SPREAD OF INFECTION (continued) 4. The Infection Control Nurse/designee will do random observations of perineal care on each shift 3 times a week X 4, then weekly X 2 months and report findings through the QA committee. Further actions will be planned and implemented if the committee deems it necessary.	4-17-09
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	483.70(h)OTHER ENVIRONMENTAL CONDITIONS (See Following Page)	

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F 465	Continued From page 52 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that the facility failed to provide a safe work environment for the staff. Findings include: Observations on 2/11/09 at 10:50 AM of the Greenbank Nourishment Room revealed a pool of water extending from the ice machine to a room wall. The ice machine was malfunctioning as well as creating a potential hazard to the staff.	F 465	483.70(h)OTHER ENVIRONMENTAL CONDITIONS 1. The Ice Machine was repaired 2/11/09 2. All Ice machines were checked to assure proper functioning. 3. The Ice Machine maintenance is a part of the preventative maintenance program. 4. The Maintenance Director will audit the compliance with the preventative maintenance program and report findings to the quality assurance committee quarterly.	2-11-09 2-11-09 4-17-09 4-17-09
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that 1 (Residents #6) out of 24 sampled residents' clinical record was maintained in accordance with accepted professional standards and practices that were complete and accurately documented. Findings include:	F 514	483.75(1)(1) CLINICAL RECORDS 1. Resident #6. Social Service notes have been updated on 2-6-09. 2. All resident charts have been audited to ensure compliance for Social Service documentation. 3. The Social Service Director/ designee will document the date of the last Social Service note on a tracking form to ensure at least quarterly documentation has occurred. Omissions will be immediately corrected and all findings will be documented.	2-6-09 4-17-09 4-17-09

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORD HEALTH SERVICES AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 53 Review of Resident #6's clinical record revealed the last social services note written was dated 6/16/08. During an interview with the social worker on 2/6/09, she acknowledged that she failed to transcribe her notes onto Resident #6's record and proceeded to update the record from 6/08 to 2/6/09.	F 514	483.75(1)(1) CLINICAL RECORDS (continued) 4. The Social Service Director/ designee will review the tracking form for accuracy weekly x4, then monthly x2. A report of the documented findings will be presented at the facility's quality assurance meetings quarterly.	4-17-09

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

STATE SURVEY REPORT

NAME OF FACILITY: Accord Health Services at Brandywine

DATE SURVEY COMPLETED: February 17, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	4/15/09 Revised report following IDR request. **The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced annual and complaint/incident investigation survey was conducted at this facility from February 4, 2009 and concluded on February 17, 2009. The deficiencies contained in this report are based on clinical record reviews, observations, review of the facility's operating procedures and interviews with residents, family and facility staff. The census on the first day of the survey was 159. The sample size included 24 standard records, which included 21 active records and three closed records, and 12 supplemental residents/records for a total of 36 residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.6.0	**Services To Residents**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort,**	

Provider's Signature Fred Gibbons Title Administrator Date 4-28-09 Revised

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	safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/17/09, F157, F253, F281, F309, F323, F325, F328, F329, F444, F465, and F514.	Please refer to the P.O.C. on the 2567-L report date completed 2-17-09 for F157, F253, F281, F309, F323, F325, F328, F329, F444, F465 and F514.	4-17-09
3201.6.5	**Nursing Administration**		
3201.6.5.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/17/09, F279.	Please refer to the P.O.C. on the 2567-L report date completed 2-17-09 for F279.	4-17-09

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3201.6.6	**Activities**		
3201.6.6.1	**The nursing facility's activities program shall provide diversified individual activity plans and group activities for each resident based on the comprehensive assessment as well as an activity assessment conducted by the activity director. The activities offered shall reflect the needs. interests, abilities, preferences, limitations and age of each resident.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/17/09, F248.	Please refer to the P.O.C. on the 2567-L report date completed 2-17-09 for F248.	4-17-09
3201.6.11	**Medications**		
3201.6.11.1	**Medication Administration**		
3201.6.11.1.1	**All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering**		

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	physician or prescriber within 10 days. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/17/09, F333.	Please refer to the P.O.C. on the 2567-L report date completed 2-17-09 for F333.	4-17-09
3201.6.12	**Communicable Diseases**		
3201.6.12.3	**Immunizations**		
3201.12.3.2	**All facilities shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control unless medically contraindicated.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/17/09, F334.	Please refer to the P.O.C. on the 2567-L report date completed 2-17-09 for F334.	4-17-09
3201.6.13	**Infection Control**		
3201.6.13.1	**Infection Control Committee**		
3201.6.13.1.5	**The infection control coordinator shall maintain records of all nosocomial infections and**		

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	corrective actions related to those infections to enable the committee to analyze clusters or significant increases in the rate of infection and to make recommendations for the prevention and control of additional cases. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/17/09, F441.	Please refer to the P.O.C. on the 2567-L report date completed 2-17-09 for F441.	4-17-09
3201.10.0	**Records and Reports**		
3201.10.1	**There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:**		
3201.10.1.11	**Special service notes, e.g., social services, activities, specialty consultations, physical therapy, dental, podiatry.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 2/17/09, F514.	Please refer to the P.O.C. on the 2567-L report date completed 2-17-09 for F514.	4-17-09

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